OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT
Invalid Usage of Diagnosis Codes

V0001 V CODES INVALID AS PRINCIPAL DIAGNOSES

Guideline: V codes are for use in both the inpatient and outpatient settings. However, they are generally more applicable to the outpatient setting. The V codes should not be first listed as principal diagnosis.

Category V21 and code V22.2 indicate additional information about the patient's status or condition, which may affect the course of treatment and its outcome.

Categories V12-V15 (history of) should be assigned when the previous condition is significant for the current episode of care. The history codes indicate that the patient no longer has the condition. The use of codes from categories V12-V15 as principal diagnoses is inappropriate.

Categories V42-V46 and subcategories V49.6 and V49.7 are for use only if there are no complications or malfunctions of the organ or tissue replaced, the amputation site or the equipment on which the patient is dependent. These are always secondary codes.

Categories V62-V64 are used as additional codes, which provide useful information on circumstances that may affect a patient's care and treatment.

Code V66.7 for palliative care should be sequenced second.

Diagnosis Table Only

ICD-9-CM Codes	ICD-9-CM Interpretations
~~V09~~	~~Infection with drug-resistant microorganisms~~ discontinued 1-1-01
~~V10~~	~~Personal history of malignant neoplasm~~ discontinued 10-1-98
V12	Personal history of certain other diseases (infections, nutritional deficiency, disorders of nervous, circulatory, respiratory, digestive, & sense organs systems, diseases of blood forming organs, endocrine, metabolic & metabolic disorders)
V13	Personal history of other diseases (disorders of urinary system, trophoblastic disease, diseases of skin, disorders of genital, obstetrical, musculoskeletal systems, and perinatal problems) *Except: V13.4 Personal history of arthritis* *V13.69 Personal history of other congenital malformations*
V14	Personal history of allergy to medicinal agents

V0001 **V CODES INVALID AS PRINCIPAL DIAGNOSES** - CONTINUED
(see guideline on page 1)

Diagnosis Table 3005

ICD-9-CM Codes	ICD-9-CM Interpretations
V15	Personal history presenting hazards to health (allergy, major surgery, irradiation, injury, poisoning, psychological trauma, and noncompliance) *Except: V15.7 Personal history of contraception*
~~V16~~	~~Family history of malignant neoplasm~~ *discontinued 10/1/98*
~~V17~~	~~Family history of certain chronic disabling diseases~~ *discontinued 10/1/98*
~~V18~~	~~Family history of certain other specific conditions~~ *discontinued 10/1/98* (diabetes, anemia, mental retardation, blood and digestive disorders, & diseases of kidney, genitourinary, infections and parasites)
~~V19~~	~~Family history of other conditions~~ *discontinued 10/1/98* (blindness, deafness, eye or ear disorders, skin conditions, congenital anomalies, allergic disorders, consanguinity)
V21	Constitutional states in development (puberty, rapid growth, adolescence)
V22.2	Pregnant state, incidental
V26.5	Sterilization Status
V42	Organ or tissue replaced by transplant
V43	Organ or tissue replaced by other means
V44	Artificial opening status
V45	Other postsurgical status *Except: V45.7 acquired absence of organ*
V46	Other dependence on machines
V49.6x	Problems with upper limb amputation status
V49.7x	Problems with lower limb amputation status
V49.82	Dental sealant status
V60	Housing, household, and economic circumstances
V62	Other psychosocial circumstances
~~V63~~	~~Unavailability of other medical facilities for care~~ discontinued 1-1-01
V64	Persons encountering health services for specific procedures, not carried out
V66.7	Encounter for palliative care

Exception: The code listed below may be used as principal diagnosis for the period of 01-01-91 to 09-30-91. During that period, the V history code V10.6x was allowed to be coded as principal diagnosis for bone marrow transplant until a new code was developed on 10-01-91 (codes 203-208 with 5th digit "2").

V10.6x	History of leukemia -- **Only for bone marrow transplant cases**
V10.6x	Federal Register, Volume 55, Number 90, May 9, 1990, page 19430

V0001 **V CODES INVALID AS PRINCIPAL DIAGNOSES** - CONTINUED
(see guideline on page 1)

References: Coding Clinic for ICD-9-CM, AHA, Nov/Dec, 1986, page l; Jan/Feb, 1987, pages 7 and 15; 4th Quarter 1990, page 3; 1st Quarter, 1991, page 6; 4th Quarter, 1996, pages 49-62; 4th Quarter, 1998, pages 47-51; 4th Quarter, 1998, pages 61-72; 4th Quarter 2001, pages 56-59.

ICD-9-CM Codebook, V Code chapter, 1990.

DRG Definition Manual, Medicare code edits #10 of Unacceptable principal diagnoses, 1990, pages 1042-1047.

ICD-9-CM Coding Handbook with Answers, AHA, 1989, Faye Brown, RRA, page 63-73; 1991, pages 66-77.

V02	Coding Clinic for ICD-9-CM, by AHA, 3rd Quarter 1994, page 4.
V10	ICD-9-CM Coding Handbook with Answers, AHA, Faye Brown, RRA, 1989, page 259 (last sentence) and 1991, page 289.
V10	Coding Clinic for ICD-9-CM, by AHA, 1994, Volume 11, No 5, page 16; 1st Quarter 1995, page 4; 2nd Quarter 1995, page 8.
V12	Coding Clinic for ICD-9-CM, by AHA, 4th Quarter 1994, page 43.
V12.5	Coding Clinic for ICD-9-CM, by AHA, 4th Quarter 1995, page 61.
V12.7	Coding Clinic for ICD-9-CM, by AHA, 1st Quarter 1995, page 3.
V13	Coding Clinic for ICD-9-CM, by AHA, 4th Quarter 1994, page 43.
V15.8	Coding Clinic for ICD-9-CM, by AHA, 4th Quarter 1995, page 62.
V15.82	Coding Clinic for ICD-9-CM, by AHA, 4th Quarter 1994, page 44.
V40-V49	JAMRA, October 1983, page 31.
V40-V49	Coding Clinic for ICD-9-CM, by AHA, 2nd Quarter 1994, page 9.
V42.1	Coding Clinic for ICD-9-CM, by AHA, 2nd Quarter 1994, page 13.
V45.89	Coding Clinic for ICD-9-CM, by AHA, 1st Quarter 1995, page 11.
V49.6	Coding Clinic for ICD-9-CM, by AHA, 4th Quarter 1994, page 39.
V49.7	Coding Clinic for ICD-9-CM, by AHA, 4th Quarter 1994, page 40.
V64.1	Coding Clinic for ICD-9-CM, by AHA, May/Jun 1984, page 11; Mar/Apr 1985, page 13; Jan/Feb 1987, page 12; *Volume 10, No 5, 1993, page 9-10 (PRO)*.
V64.2	Coding Clinic for ICD-9-CM, by AHA, Jan/Feb 1987, page 13.
V66.7	Coding Clinic for ICD-9-CM, by AHA, 4th Quarter, 1996, page 47; 1st Quarter 1998, pages 11-12.
V66.7	Federal Register, Volume 61, Number 170, August 30, 1996, pages 46175-46176.

~~V0002 OUTPATIENT SERVICE V CODES INVALID AS INPATIENT PRINCIPAL DIAGNOSES~~ - *effective change as of 10/1/96*

Guideline: There are certain services that are not usually reasons for admission to an acute care facility. Most of these are found with the ICD-9-CM "V" codes. The V codes are divided into service and problem categories. The service "V" codes may be the principal diagnosis when the reason of admit is for a specific service. It is correct to code some of the services as principal diagnosis only for care provided in outpatient settings.

DRG Definition Rule:

There are selected codes that describe a circumstance which influences an individual's health status but is not a current illness or injury. Therefore, these codes are considered unacceptable as principal diagnosis.

Diagnosis Table Only

Category	ICD-9-CM Codes	ICD-9-CM Interpretations
Service	V03	Prophylactic vaccination and inoculation against bacterial diseases
Service	V04	Prophylactic vaccination and inoculation against certain viral diseases
Service	V05	Prophylactic vaccination and inoculation against single diseases
Service	V06	Prophylactic vaccination and inoculation against combination of diseases
Service	V07	Need for isolation and other prophylactic measures (desensitization to allergens, immunotherapy, prophylactic chemotherapy such as antibiotics and other chemotherapeutic agents)
		V07.1 Desensitization to allergens
		V07.2 Prophylactic immunotherapy
		V07.3 Other prophylactic chemotherapy
		V07.4 Postmenopausal hormone replacement therapy
		V07.9 Unspecified prophylactic measure
Service	V22	Normal pregnancy
Service	V23	Supervision of high-risk pregnancy
Service	V24	Postpartum care and examination
		V24.1 Lactating mother
		V24.2 Routine postpartum follow-up
Service	V28	Antenatal screening
Service	V50	Elective surgery for purposes other than remedying health status
		V50.3 Ear piercing
		V50.8 Other
		V50.9 Unspecified
Service	V52	Fitting and adjustment of prosthetic device

~~V0002~~ **~~OUTPATIENT SERVICE V CODES INVALID AS INPATIENT~~** **~~PRINCIPAL DIAGNOSES~~** *~~effective~~ change as of 10/1/96*

Diagnosis Table Only

Category	ICD-9-CM Codes	ICD-9-CM Interpretations
Service	V53	Fitting and adjustment of other device *Excludes: V53.3 Fitting and adjustment of cardiac device*
Service	V59	Donors V59.0 Blood only
Service	V65	Other persons seeking consultation without complaint or sickness *Excludes: V65.2 Person feigning illness and seeking consultation*
Service	V68	Encounter for administrative purposes
Service	V70	General medical examinations
Service	V72	Special investigations and examinations
Service	V73	Special screening examination for viral disease
Service	V74	Special screening examination for bacterial and spirochetal diseases
Service	V75	Special screening for examination for other infectious diseases
Service	V76	Special screening for malignant neoplasm
Service	V77	Special screening for endocrine, nutritional, metabolic, and immunity disorders
Service	V78	Special screening for disorders of blood and blood-forming organs
Service	V79	Special screening for mental disorders and developmental handicaps
Service	V80	Special screening for neurological, eye, and ear diseases
Service	V81	Special screening for cardiovascular, respiratory, and genitourinary diseases
Service	V82	Special screening for other conditions (skin, rheumatoid, congenital dislocation, chromosomal anomalies, chemical poisonings, multiphasic screening)

References: ICD-9-CM Codebook, V code chapter, 1990.

DRG Definition Manual, Medicare code edits #10 of unacceptable principal diagnoses, 1990, pages 1042-1047.

ICD-9-CM Coding Handbook With Answers, by AHA, 1989, Faye Brown, RRA, page 63-73.

V70	Coding Clinic for ICD-9-CM, AHA, Nov/Dec 1985, page 13.
V70.3	Coding Clinic for ICD-9-CM, AHA, lst Quarter 1990, page 6.
V72	Coding Clinic for ICD-9-CM, AHA, Nov/Dec 1985, page 13.
V72.8	Coding Clinic for ICD-9-CM, AHA, lst Quarter 1990, page 5-6, 10.
V72.6	Coding Clinic for ICD-9-CM, AHA, lst Quarter 1990, page 22.
V72.5	Coding Clinic for ICD-9-CM, AHA, lst Quarter 1990, pages 19-21.
V72.5	JAMRA, October 1989, pages 19-20.

V0003 CLASSIFICATION OF BIRTHS TOO VAGUE FOR A PRINCIPAL DIAGNOSIS

Guideline: Categories V33, V37, and V39 are too vague and should not be used in the acute care facility. Sufficient information regarding the birth is usually available to permit assignment of a more specific code.

Diagnosis Table Only

ICD-9-CM Codes	ICD-9-CM Interpretations
V33.00	Twin, unspecified, born in hospital, no cesarean section
V33.01	Twin, unspecified, delivered by cesarean section
V33.1	Twin, unspecified, born before admission to hospital
V37.00	Other multiple birth, unspecified, born in hospital, no cesarean section
V37.01	Other multiple birth, unspecified, delivered by cesarean section
V37.1	Other multiple birth, unspecified, born before admission to hospital
V39.00	Unspecified birth, born in hospital, no cesarean section
V39.01	Unspecified birth, delivered by cesarean section
V39.1	Unspecified birth, born before admission to hospital

References: ICD-9-CM Coding Handbook with Answers, AHA, Faye Brown, RRA, 1989, page 207; 1991, page 239.

V0004 LATE EFFECTS INVALID AS PRINCIPAL DIAGNOSES

Guideline: Late effect is a residual condition produced after the acute phase of an illness or injury has terminated. There is no time limit on when a late effect code can be used.

Coding of late effects require two codes in this order: first - the residual condition and second - the late effect code. Exception: If residual is unknown, the late effect code for the cause can be used alone. These late effect codes are not usually reasons for admission.

Diagnosis Table Only

ICD-9-CM Codes	ICD-9-CM Interpretations
137.0 - 137.4	Late effect - tuberculosis
138	Late effect - poliomyelitis
139.0 - 139.8	Late effect - infectious & parasitic diseases
268.1	Late effect - rickets
326	Late effect - intracranial abscess or pyogenic infection
905.0 - 909.9	Late effect - injuries, poisonings, toxic effects, other external causes

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References: ICD-9-CM Codebook, 1990, on the above listed codes.

ICD-9-CM Coding Handbook with Answers, Revised Edition, 1989, Faye Brown, RRA, pages 43-50, 90-91, 233-235, 283-284, 307-308, 312-313; 1994, page 50-53, 88, 276, 330, 345, 366-367, 398.

ICD-9-CM Coding and Reporting Official Guidelines, AHA, AMRA, HCFA, & NCHS, Item 1.7.

Coding Clinic, May/Jun 1984, pages 6-7; Mar/Apr 1985, page 14; Mar/Apr 1986, pages 5-6; 2nd Quarter 1990, pages 6-7.

JAMRA, September 1985, pages 14-16.

139.8 Coding Clinic for ICD-9-CM, AHA, Mar/Apr 1987, page 8; 3rd Quarter 1990, page 14.

438.x Coding Clinic for ICD-9-CM, AHA, 4th Quarter, 1997, pages 35-36.

V0004 **LATE EFFECTS INVALID AS PRINCIPAL DIAGNOSES** - CONTINUED

References: 438 JAMRA, June 1984 and October 1984, ICD-9-CM Notes.

438 Coding Clinic, Mar/Apr 1985, page 7; Mar/Apr 1986, page 7; Nov/Dec 1986, page 12; 2nd Quarter 1989, page 8.

905.6 Coding Clinic, Mar/Apr 1985, page 4.

905.8 Coding Clinic, 2nd Quarter 1989, pages 13, 15.

907.0 Coding Clinic, Nov/Dec 1987, page 12.

909.0 Coding Clinic, Sep/Oct 1984, page 16.

909.2 Coding Clinic, Nov/Dec 1984, page 17.

CMRA Coding Module 2, 1988-1989, pages 33, 56, 70-71, 137, 155, 243, 247-248, 257-259, 267, 272.

CMRA Newsletter, April 1990, page 12.

V0005 OLD HISTORY OF MYOCARDIAL INFARCTION INVALID AS PRINCIPAL DIAGNOSIS

Guideline: This condition is usually not the reason for admission to an acute care hospital. Old myocardial infarction is classified to code 412. When symptoms are present, appropriate codes for these conditions should be assigned; code 412 should not be used. Code 412 is never designated as a principal diagnosis for inpatients. It is not ordinarily assigned when current infarction or acute or subacute ischemic disease is present.

Diagnosis Table Only

ICD-9-CM Codes	ICD-9-CM Interpretations
412	Old Myocardial Infarction

References: ICD-9-CM Coding Handbook with Answers, AHA, 1991, Faye Brown, RRA, page 251.

ICD-9-CM Coding Handbook with Answers, AHA, 1989, Faye Brown, RRA, pages 222-223.

JAMRA, April 1980, ICD-9-CM Notes, page 64.
The statement of an old or healed myocardial infarction would be coded in addition to any statement of current angina pectoris, new myocardial infarction or coronary insufficiency.

CMRA Coding Module 2, 1983, page 83.

Coding Clinic, Jul/Aug 1984, pages 6-7.

CPHA Workshop - 1987, page 7.
Code 412 includes myocardial infarction specified as old or healed or diagnosed on ECG or other special investigation but currently presenting no symptoms. The use of category 412 is like a "V" code in that it represents a "history" or "status" of a myocardial infarction.

CMRA Coding Module 2, 1988/1989, page 149.
*Code 412 is used to designate a healed myocardial infarction without symptoms. It is **not** used when any heart symptoms are present (see 414.8). Code 412 is never the reason for an acute care hospital admission and should not appear as a principal diagnosis.*

$ HIV TEST RESULTS REPORTED AS A PRINCIPAL DIAGNOSIS OR SECONDARY DIAGNOSIS
(No longer a coding edit V0006, instead it is an OSHPD edit within California)

Guideline: The HIV test result is usually not the reason for admission to an acute care hospital. An abnormal HIV test rarely affects treatment or resource consumption; therefore, it should not be coded. California Code of Regulations prohibits the disclosure of any results of an HIV test whether positive, negative, or inconclusive without patient's authorization to each entity.

Diagnosis Table Only

ICD-9-CM Codes	ICD-9-CM Interpretations
795.8	Positive serological or viral culture findings for human immunodeficiency virus (HIV) before 10-01-94
795.71	Nonspecific serologic evidence of human immunodeficiency virus [HIV] after 10-01-94
V08	Asymptomatic human immunodeficiency virus [HIV] infection status after 10-01-94

References: ICD-9-CM Chapter 16 - Coding instruction found at the beginning of the chapter in the third paragraph.

Coding Clinic, AHA, 2nd Quarter, 1990, page 3 - Symptom coding rule.

Journal of CHIA, February 1993, Vol 42, No 2, pages 13-14; December 94/January 95, Vol 43/44, No 1, pages 9-10.

CMRA Coding Module II, 1988-1989, pages 72-73; 1991, pages 57-58.

ICD-9-CM Coding Handbook with Answers, AHA, Faye Brown, RRA, 1989, pages 92-98; 1991, pages 104-108, 1999 pg 89

Morbidity and Mortality Weekly Report (MMWR), December 18, 1992, Vol. 41, No. RR-17, page 9.

California Code of Regulations, Health and Safety Code, Division 1, Chapter 1.11 Mandated Blood Testing and Confidentiality to Protect Public Health, Sections 199.20 and 199.21.

V0007 UNSPECIFIED INJURIES TOO VAGUE FOR A PRINCIPAL DIAGNOSIS

Guideline: There are certain nonspecific diagnosis codes that are too vague to use for the principle diagnosis and should be avoided if possible. Sufficient information regarding the injuries is usually available to permit assignment of a more specific code. It should be noted that a diagnosis is considered nonspecific principal diagnosis only if the patient was discharged alive. The record should be searched for more specific information. If there is no documentation for further specificity, the physician should be asked for further information. Since patients who have died often do not receive a complete diagnostic workup, the specification of precise principal diagnosis may not be possible.

Diagnosis Table Only

ICD-9-CM Codes	ICD-9-CM Interpretations
829.0	Fracture of unspecified bone, closed
829.1	Fracture of unspecified bone, open
839.8	Multiple and ill-defined dislocation, closed
839.9	Multiple and ill-defined dislocation, open
848.9	Unspecified site of sprain and strain
869.0	Internal injury to unspecified or ill-defined organs without mention of open wound into cavity
869.1	Internal injury to unspecified or ill-defined organs with mention of open wound into cavity
879.8	Open wound of unspecified site without mention of complication
879.9	Open wound of unspecified site, complicated
959.9	Injury, unspecified site

References: Coding Clinic for ICD-9-CM, AHA, May/June 1984, List of Nonspecific Principal Diagnoses.

DRG Definition Manual, Medicare Code Edit #8 - Nonspecific Principal Diagnoses.

CMRA Coding Module 2, 1989, pages 244-245 and 1991, pages 191-192.

V0008 BURNS OF UNSPECIFIED SITES ARE TOO VAGUE FOR A PRINCIPAL DIAGNOSIS

Guideline: Category 949, Burns, unspecified sites, is extremely vague and should rarely be used in an acute care facility. It should be noted that a diagnosis is considered nonspecific principal diagnosis only if the patient was discharged alive. The record should be searched for more specific information. If there is no documentation for further specificity, the physician should be asked for further information. Since patients who have died often do not receive a complete diagnostic workup, the specification of precise principal diagnosis may not be possible.

Diagnosis Table Only

ICD-9-CM Codes	ICD-9-CM Interpretations
949.0	Burn, unspecified degree
949.1	Erythema [first degree]
949.2	Blisters, epidermal loss [second degree]
949.3	Full-thickness skin loss [third degree NOS]
949.4	Deep necrosis of underlying tissues [deep third degree] without mention of loss of a body part
949.5	Deep necrosis of underlying tissues [deep third degree] with loss of a body part

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References: ICD-9-CM Coding Handbook with Answers, AHA, Faye Brown, RRA, 1989, page 297; 1991, page 325.

Coding Clinic for ICD-9-CM, AHA, May/June 1984, List of Nonspecific Principal Diagnoses.

DRG Definition Manual, Medicare Code Edit #8 - Nonspecific Principal Diagnoses.

V0009 COMPLICATIONS OF TRAUMA QUESTIONABLE AS PRINCIPAL DIAGNOSIS

Guideline: Category 958 classifies certain early complications of trauma such as air or fat embolism, traumatic shock, traumatic anuria, traumatic subcutaneous emphysema, Volkmann's ischemic contracture, secondary and recurrent hemorrhage and posttraumatic wound infection. These conditions are not included in the original codes identifying the injury.

Codes from category 958 are assigned as secondary codes, with the code for the injury sequenced first. This is still essentially true, especially when the admission is for the purpose of treating the current injury. With today's shorter average length of stay and increased emphasis on outpatient care, the complication itself may occasionally be the reason for the outpatient encounter (or the condition occasioning admission) after treatment for the original injury has been completed.

Diagnosis Table Only

ICD-9-CM Codes	ICD-9-CM Interpretations
958.0	Air embolism
958.1	Fat embolism
958.2	Secondary and recurrent hemorrhage
958.3	Posttraumatic wound infection, NEC
958.4	Traumatic shock
958.5	Traumatic anuria
958.6	Volkmann's ischemic contracture
958.7	Traumatic subcutaneous emphysema
958.8	Other early complications of trauma

References: Coding Clinic for ICD-9-CM, AHA, Sept-Oct 1985, page 10; Mar-Apr 1986, page 9.

Coding Clinic for ICD-9-CM, AHA, 2nd Quarter 1991, page 6; *Vol 10, No 5, 1993, page 3 (PRO)*.

ICD-9-CM Coding Handbook with Answers, AHA, Faye Brown, RRA, 1989, pages 291, 298; 1991, 187, 319, 326; 1994, 196-197, 353-354.

V0010 DELIVERY OUTCOME V27 INVALID AS PRINCIPAL DIAGNOSIS

Guideline: Because the delivery codes in Chapter 11 of the ICD-9-CM Codebook do not include information regarding the outcome of delivery, a code from category V27 must be used as an additional code to provide such information as to whether a live birth resulted or whether multiple births occurred. It is used as an additional code only -- **never** as a principal diagnosis -- and in coding the mother's medical record only.

Diagnosis Table Only

ICD-9-CM Codes	ICD-9-CM Interpretations
V27.0	Outcome of delivery: Single liveborn
V27.1	Outcome of delivery: Single stillborn
V27.2	Outcome of delivery: Twins, both liveborn
V27.3	Outcome of delivery: Twins, one liveborn and one stillborn
V27.4	Outcome of delivery: Twins, both stillborn
V27.5	Outcome of delivery: Other multiple birth, all liveborn
V27.6	Outcome of delivery: Other multiple birth, some liveborn
V27.7	Outcome of delivery: Other multiple birth, all stillborn
V27.9	Outcome of delivery: Unspecified outcome of delivery

References: Coding Clinic for ICD-9-CM, AHA, 4th Quarter, 1995, Obstetrics Guidelines 5.1 D, page 26; 4th Quarter, 1996, pages 49-62; 4th Quarter, 1998, pages 61-72; 4th Quarter 2001, pages 56-59.

ICD-9-CM Coding Handbook, AHA, Faye Brown, RRA, 1989, pages 177-178; 1991, pages 212-213.

V0011 PRINCIPAL DIAGNOSIS - UNSPECIFIED ADVERSE EFFECT

Guideline: Code 995.2, Unspecified adverse effect of drug, medicinal, and biological substance, should never be used in the inpatient setting. The medical record should have some documented sign or symptom of what the adverse reaction is. However, if there is no documented adverse reaction listed in the record, then assign code 796.0, Nonspecific abnormal toxicological findings. Code 995.2 is permissible in the outpatient setting.

Diagnosis Table Only

ICD-9-CM Code	ICD-9-CM Interpretation
995.2	Unspecified adverse effect of drug, medicinal, and biological substance

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References: Coding Clinic for ICD-9-CM, AHA, 3rd Quarter, 1995, page 13; 1st Quarter, 1997, page 16.

V0012 **NONSPECIFIC V CODE AS PRINCIPAL DIAGNOSIS**

new as of 1/1/97

Guideline: Certain V codes are so nonspecific, or potentially redundant when with other codes in the classification, that there could be little justification for their use in an inpatient setting. Otherwise, any sign or symptom or any other reason for the visit that is captured in another code should be used.

Diagnosis Table Only

ICD-9-CM Code	ICD-9-CM Interpretation
V11	Personal history of mental disorder
V13.4	Personal history of arthritis
V13.69	Personal history of other congenital malformations
V15.7	Personal history of contraception
V23.2	Pregnancy with history of abortion
V40	Mental and behavioral problems
V41	Problems with special senses and other special functions
V47	Other problems with internal organs
V48	Problems with head, neck, and trunk
V49	Problems with limb and other problems
	Exceptions: V49.6 Upper limb amputation status
	V49.7 Lower limb amputation status
	V49.81 Postmenopausal status
	V49.82 Dental sealant status
V51	Aftercare involving the use of plastic surgery
V58.2	Blood transfusion, without reported diagnosis
V58.9	Unspecified aftercare
V72.5	Radiological examination, NEC
V72.6	Laboratory examination

References: Coding Clinic for ICD-9-CM, AHA, 4th Quarter, 1996, pages 58, 62; 4th Quarter, 1997, pages 47-51; 4th Quarter 1998, pages 61-72; 4th Quarter, 2001, pages 56-59.

V0013 **ITALICIZED CODE CANNOT BE A PRINCIPAL DIAGNOSIS**
n*ew as of 1/1/98*

Guideline: The diagnosis codes that are printed in italics cannot be used (designated) as principal diagnosis.

This dual classification is used to describe the assignment of two codes for certain diagnostic statements that contain information about both a manifestation and the underlying disease (etiology) with which it is associated. Mandatory multiple coding of this type is identified in the Tabular List by the use of italic type and by the printed instruction "Code also underlying disease." It is identified in the Alphabetic Index by the use of the second code in slanted brackets and italic type. The first code identifies the underlying condition (etiology) and the second italicized code identifies the manifestation listed. Both codes must be assigned.

Diagnosis Table Only

ICD-9-CM Codes	ICD-9-CM Interpretations
320.7	*Meningitis in other bacterial diseases classified elsewhere*
321.0	*Cryptococcal meningitis*
321.1	*Meningitis in other fungal diseases*
321.2	*Meningitis due to viruses not elsewhere classified*
321.3	*Meningitis due to trypanosomiasis*
321.4	*Meningitis in sarcoidosis*
321.8	*Meningitis due to other nonbacterial organisms classified elsewhere*
323.0	*Encephalitis in viral diseases classified elsewhere*
323.1	*Encephalitis in rickettsial diseases classified elsewhere*
323.2	*Encephalitis in protozoal diseases classified elsewhere*
323.4	*Other encephalitis due to infection classified elsewhere*
323.6	*Postinfectious encephalitis*
323.7	*Toxic encephalitis*
330.2	*Cerebral degeneration in generalized lipidoses*
330.3	*Cerebral degeneration of childhood in other diseases classified elsewhere*
331.7	*Cerebral degeneration in diseases classified elsewhere*
334.4	*Cerebellar ataxia in diseases classified elsewhere*
336.2	*Subacute combined degeneration of spinal cord in diseases*
336.3	*Myelopathy in other diseases classified elsewhere*
337.1	*Peripheral autonomic neuropathy in disorders classified elsewhere*
357.1	*Polyneuropathy in collagen vascular disease*
357.2	*Polyneuropathy in diabetes*
357.3	*Polyneuropathy in malignant disease*
357.4	*Polyneuropathy in other diseases classified elsewhere*
358.1	*Myasthenic syndromes in diseases classified elsewhere*
359.5	*Myopathy in endocrine disease classified elsewhere*

V0013 **ITALICIZED CODE CANNOT BE A PRINCIPAL DIAGNOSIS** –
CONTINUED (see guidelines on page 17)
n*ew as of 1/1/98*

Diagnosis Table Only

ICD-9-CM Codes	ICD-9-CM Interpretations
359.6	*Symptomatic inflammatory myopathy in diseases classified elsewhere*
362.01	*Background diabetic retinopathy*
362.02	*Proliferative diabetic retinopathy*
362.71	*Retinal dystrophy in other systemic disorders and syndromes*
362.72	*Retinal dystrophy in other systemic disorders and syndrome*
364.11	*Chronic iridocyclitis in diseases classified elsewhere*
365.41	*Glaucoma associated with chamber angle anomalies*
365.42	*Glaucoma associated with anomalies of iris*
365.43	*Glaucoma associated with other anterior segment anomalies*
365.44	*Glaucoma associated with systemic syndromes*
366.41	*Diabetic cataract*
366.42	*Tetanic cataract*
366.43	*Myotonic cataract*
366.44	*Cataract associated with other syndromes*
370.44	*Keratitis or keratoconjunctivitis in exanthema*
371.05	*Phthisical cornea*
372.15	*Parasitic conjunctivitis*
372.31	*Rosacea conjunctivitis*
372.33	*Conjunctivitis in mucocutaneous disease*
373.4	*Infective dermatitis of eyelid of types resulting in deformity*
373.5	*Other infective dermatitis of eyelid*
373.6	*Parasitic infestation of eyelid*
374.51	*Xanthelasma*
376.13	*Parasitic infestation of orbit*
376.21	*Thyrotoxic exophthalmos*
376.22	*Exophthalmic ophthalmoplegia*
380.13	*Other acute infections of external ear*
380.15	*Chronic mycotic otitis externa*
382.02	*Acute suppurative otitis media in diseases classified elsewhere*
420.0	*Acute pericarditis in diseases classified elsewhere*
421.1	*Acute and subacute infective endocarditis in diseases classified elsewhere*
422.0	*Acute myocarditis in diseases classified elsewhere*
424.91	*Endocarditis in diseases classified elsewhere*
425.7	*Nutritional and metabolic cardiomyopathy*
425.8	*Cardiomyopathy in other diseases classified elsewhere*
443.81	*Peripheral angiopathy in diseases classified elsewhere*
456.20	*Esophageal varices in diseases classified elsewhere - with bleeding*

V0013 **ITALICIZED CODE CANNOT BE A PRINCIPAL DIAGNOSIS** – CONTINUED n*ew as of 1/1/98* (see guidelines on page 17)

Diagnosis Table Only

ICD-9-CM Codes	ICD-9-CM Interpretations
456.21	*Esophageal varices in diseases classified elsewhere - without mention of bleeding*
484.1	*Pneumonia in cytomegalic inclusion disease*
484.3	*Pneumonia in whooping cough*
484.5	*Pneumonia in anthrax*
484.6	*Pneumonia in aspergillosis*
484.8	*Pneumonia in other infectious diseases classified elsewhere*
516.1	*Idiopathic pulmonary hemosiderosis*
517.1	*Rheumatic pneumonia*
517.2	*Lung involvement in systemic sclerosis*
517.8	*Lung involvement in other diseases classified elsewhere*
567.0	*Peritonitis in infectious diseases classified elsewhere*
573.1	*Hepatitis in viral diseases classified elsewhere*
573.2	*Hepatitis in other infectious diseases classified elsewhere*
580.81	*Acute glomerulonephritis in diseases classified elsewhere*
581.81	*Nephrotic syndrome in diseases classified elsewhere*
582.81	*Chronic glomerulonephritis in diseases classified elsewhere*
583.81	*Nephritis and nephropathy, not specified as acute or chronic, in diseases classified elsewhere*
590.81	*Pyelitis or pyelonephritis in diseases classified elsewhere*
595.4	*Cystitis in diseases classified elsewhere*
598.01	*Urethral stricture due to infective diseases classified elsewhere*
601.4	*Prostatitis in diseases classified elsewhere*
604.91	*Orchitis and epididymitis in diseases classified elsewhere*
608.81	*Disorders of male genital organs in diseases classified elsewhere*
616.11	*Vaginitis and vulvovaginitis in diseases classified elsewhere*
616.51	*Ulceration of vulva in diseases elsewhere*
628.1	*Infertility, female, of pituitary-hypothalamic origin*
711.10-711.19	*Arthropathy associated with Reiter's disease and nonspecific urethritis*
711.20-711.29	*Arthropathy associated with Behcet's syndrome*
711.30-711.39	*Postdysenteric arthropathy*
711.40-711.49	*Arthropathy associated with other bacterial diseases*
711.50-711.56	*Arthropathy associated with other viral diseases*
711.60-711.69	*Arthropathy associated with mycoses*

V0013 **ITALICIZED CODE CANNOT BE A PRINCIPAL DIAGNOSIS** – CONTINUED n*ew as of 1/1/98* (see guidelines on page 17)

Diagnosis Table Only

ICD-9-CM Codes	ICD-9-CM Interpretations
711.70-711.79	*Arthropathy associated with Helminthiasis*
711.80-711.89	*Arthropathy associated with other infectious and parasitic diseases*
712.10-712.19	*Chondrocalcinosis due to dicalcium phosphate crystals*
712.20-712.29	*Chondrocalcinosis due to pyrophosphate crystals*
712.30-712.39	*Chondrocalcinosis, unspecified*
713.0	*Arthropathy associated with other endocrine and metabolic disorders*
713.1	*Arthropathy associated with gastrointestinal conditions other than infections*
713.2	*Arthropathy associated with hematological disorders*
713.3	*Arthropathy associated with dermatological disorders*
713.4	*Arthropathy associated with respiratory disorders*
713.5	*Arthropathy associated with neurological disorders*
713.6	*Arthropathy associated with hypersensitivity reaction*
713.8	*Arthropathy associated with other conditions classifiable elsewhere*
713.7	*Other general diseases with articular involvement*
720.81	*Inflammatory spondylopathies in diseases classified elsewhere*
727.01	*Synovitis and tenosynovitis in diseases classified elsewhere*
730.70-730.79	*Osteopathy resulting from poliomyelitis*
730.80-730.89	*Other infections involving bone in diseases classified elsewhere*
731.1	*Osteitis deformans in diseases classified elsewhere*
731.8	*Other bone involvement in diseases classified elsewhere*
737.40	*Curvature of spine, unspecified*
737.41	*Kyphosis*
737.42	*Lordosis*
737.43	*Scoliosis*
774.0	*Perinatal jaundice from hereditary hemolytic anemias*
774.31	*Neonatal jaundice due to delayed conjugation in diseases classified elsewhere*
774.5	*Perinatal jaundice from other causes*

V0013 **ITALICIZED CODE CANNOT BE A PRINCIPAL DIAGNOSIS** – CONTINUED n*ew as of 1/1/98*

References: ICD-9-CM Codebook, Conventions used in the Disease Tabular List, Read definition of "Code Also Underlying Disease."

ICD-9-CM Coding Handbook with Answers, AHA, Faye Brown, RRA, 1989, page 38; 1991, page 42; 1994, page 44.

Coding Clinic for ICD-9-CM, AHA, Jan-Feb 1986, page 9; 2nd Quarter 1993, page 6; Official Guidelines for Coding and Reporting, Rule 1.6B.

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NEXT V-EDIT IS V0041